MHSOAC PREVENTION AND EARLY INTERVENTION COMMITTEE PROPOSAL

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Introduction

The Mental Health Services Oversight and Accountability Commission (MHSOAC) was established in July 2005 by the Mental Health Services Act (MHSA). The MHSOAC is responsible for ensuring that MHSA funds are utilized properly throughout California. The MHSOAC created a Prevention and Early Intervention (PEI) Committee that consists of 5 Commissioners (Mary Hayashi, Darlene Prettyman, Carmen Diaz, Jerry Doyle, and Saul Feldman), 15 public members representing various mental health constituencies, including public mental health clients, family members of the children and adults using the public mental health system, service providers, the State Department of Mental Health, and the California Mental Health Directors. The Committee began meeting in January 2006 to provide to the MHSOAC with broad policy recommendations in Prevention and Early Intervention. Their objectives included:

1. Defining Prevention and Early Intervention in accord with the statute requirements
2. Identifying Prevention and Early Intervention Vision and Guiding Principles
3. Identifying Prevention and Early Intervention Program Criteria
4. Identifying Prevention and Early Intervention State and County Priority Populations

MHSA Prevention and Early Intervention Program Requirements

The following is a summary of MHSA statutory requirements regarding Prevention and Early Intervention Programs. Sections in bold are referenced later in this document as they provide a critical context to the MHSOAC PEI Committee's policy recommendations for the full Mental Health Services Oversight and Accountability Commission.

PART 3.6 PREVENTION AND EARLY INTERVENTION PROGRAMS

5840.

(a) The Department of Mental Health shall establish a program designed to **prevent mental illnesses from becoming severe and disabling.** The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

1. Outreach to families, employers, primary health care providers, and others **to recognize the early signs of potentially severe and disabling mental illnesses**.
2. Access and linkage to medically necessary care provided by **county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable**.
3. **Reduction in stigma** associated with either being diagnosed with a mental illness or seeking mental health services.
4. **Reduction in discrimination** against individuals and their families living with mental illness**.**

(c) The program shall include mental health services **similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated sever mental illness**es and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to **reduce the following negative outcomes** that may result from untreated mental illness:

1. **Suicide**
2. **Incarcerations**
3. **School failure or dropout**
4. **Unemployment**
5. **Prolonged suffering**
6. **Homelessness**
7. **Removal of children from their homes.**

(e) In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years **to reflect what is learned about the most effective prevention and intervention programs for children, adults and seniors.**

Definition of Prevention

Prevention occurs across the entire mental health intervention spectrum. The following describes *what* prevention is:

1. **Prevention:** Interventions to reduce the risk of the initial onset of a mental disorder.
2. **Treatment:** Interventions to reduce the length of time the disorder continues, stop the progression of severity, and stop the recurrence of the disorder or increase the length between episodes; and
3. **Maintenance:** Interventions to reduce relapse and recurrence and provide rehabilitation.

The scope of those interventions that fall within Prevention efforts (this can be understood as *how* Prevention efforts address various populations) is described below:

1. **Universal** -- Intended to reach all members of the community;
2. **Selective** -- Directed toward people with some risk, often based on their membership in a vulnerable subgroup; and
3. **Indicated** -- For people identified as having the greatest risk based on specific symptoms or signs but who lack the criteria for a mental health diagnosis.

There are growing efforts to describe prevention in positive terms. Prevention promotes positive cognitive, social, and emotional development, and encourages a state of well being that allows a person to function well in the face of changing and sometimes challenging circumstances. Prevention in mental health reduces risk factors or stressors, builds skills, and increases connections and supports. The MHSA requires and inspires an approach to prevention that is integrated, accessible, culturally relevant, strength-based, and cost effective. Frameworks for prevention using the language and concepts of recovery and resilience need to be developed and disseminated.

Decision Point for the Commission: Prevention Interventions

The primary relevance of a definition of prevention is to provide a common framework for key decisions, the most fundamental of which is to specify what kinds of programs and interventions will be eligible for and prioritized under MHSA prevention funding**.** The PEI Committee recommends the adoption of the prevention intervention spectrum described above for purposes of defining eligible levels of prevention to be funded by the MHSA. This recommendation leads to a decision-making point to be considered by the MHSOAC.

Committee Consensus Finding: Prevention occurs across the entire mental health intervention spectrum, which includes: **a) Prevention:** Interventions to reduce the risk of the initial onset of a mental disorder; **b) Treatment**: Interventions to reduce the length of time the disorder continues, stop the progression of severity, and stop the recurrence of the disorder or increase the length between episodes; **and c) Maintenance**: Interventions to reduce relapse and recurrence and provide rehabilitation.

Committee members could not come to consensus with regard to the issue of funding emphasis, and therefore provide the Commission with the following choices:

Option One: Funding emphasis for demonstrated and promising prevention interventions should be prioritized to prevent the initial onset of a mental disorder **(Prevention)** as well as to provide **early interventions** (e.g. "first break").

Option Two: Funding for demonstrated and promising prevention interventions should be available across the entire mental health intervention spectrum, which includes interventions to prevent the initial onset of a mental disorder **(Prevention);** interventions to reduce the length of time the disorder continues, stop the progression of severity, and stop the recurrence of the disorder or increase the length between episodes **(Treatment);** and interventions to reduce relapse and recurrence and provide rehabilitation **(Maintenance).**

Vision, Principles, Criteria, & Priority Populations

Vision Statement

All Californians share responsibility for promoting strong mental health and resiliency among individuals in their many diverse communities and for supporting individuals in accessing mental health services without fear of disapproval or discrimination.

Prevention and early intervention approaches are tools for empowerment and social justice that emphasize holistic and integrated approaches to mental health.

Principles and Criteria

Below are the MHSOAC PEI Committee recommendations for foundational principles and program criteria. The Committee has distinguished principles and criteria in the following way. *Principles* are values that provide guidance and inspiration, while *criteria* are standards used to make funding decisions to help ensure that prevention and early intervention efforts reflect identified principles and contribute to transforming California's mental health system.

1. **Transformational Strategies and Actions**:
   - Principle: County and state prevention and early intervention (PEI) efforts align with *transformational values* defined in recent reports such as the

Mental Health Services Act, the DMH Vision and Guiding Principles of the MHSA, and the President's New Freedom Commission Report.

- Criteria: Transformational values are to be demonstrated in county and state programs, including the following:
    i. Strategies for Prevention and Early Intervention are driven by consumers and family/caregivers, with specific attention to those from underserved communities.
    ii. Culturally and linguistically competent
    iii. Demonstrate system partnerships, community collaboration, and integration
    iv. Focused on wellness, resiliency and recovery
    v. Include evidence indicating high likelihood of effectiveness and methodology to demonstrate outcomes.

2. **Leveraging Resource:**
    - Principle: County and state PEI efforts extend MHSA programs and funding by leveraging resources and funding sources, including ones not traditionally identified as mental health, to significantly increase the total resources brought to bear to address mental health issues.
    - Criteria: In order to extend the impact of MHSA PEI funding, county and state programs demonstrate collaborations that include shared resources or other strategies to leverage additional resources beyond MHSA funds.

3. **Reduction of Disparities:**
    - Principles: County and State PEI programs shall emphasize the goal of reducing disparities.
    - Criteria: County and state PEI program designs use promising and demonstrated strategies effective in reducing racial, ethnic, cultural, language, gender, age, economic, and other disparities in mental health services (access, quality) and outcomes.

4. **Stigma Reduction:**
    - Principle: PEI programs reduce stigma associated with having a mental illness and or social/emotional/behavioral disorders for those seeking services and supports for mental health issues.
    - Criteria:
        i. PEI efforts emphasize strategies to reduce stigma associated with mental illness.

ii. PEI efforts demonstrate strategies to move toward a positive, non-stigmatized "help first" approach reflective of a society that recognizes and honors its responsibility to assist persons with mental health issues.

iii. PEI efforts include strategies customized for each racial, ethnic or other special population.

5. **Reduction of Discrimination**:

- Principle: PEI efforts emphasize strategies to reduce discrimination against individuals living with mental illness or social/emotional/behavioral disorders, including limited opportunities, abuse, a various negative consequences, and barriers to recovery.
- Criteria: PEI programs use strategies that are promising and have demonstrated effectiveness in eliminating discrimination against persons living with mental illness and their families.

6. **Recognition of Early Signs:**

- Principle: County and state PEI program plans shall include critical linkages with those in the best position to recognize early signs of mental illness and intervene, including but not limited to, parents and care givers, primary health care providers, early childhood education providers, teachers, faith based providers and traditional healers.

- Criteria:
  i. Counties must conduct a workforce and capacity assessment to ensure they are not creating PEI programs that duplicate those that already exist in their County. They shall document their efforts to identify, outreach to, and collaborate with existing community-based organizations, primary care providers, mental health providers, parents and care givers, early childhood education providers, teachers, faith based organizations and traditional healers. The capacity assessment will assess gaps in services to determine areas of greatest need.
  ii. Prior to Counties establishing new programs within their own infrastructure, Counties must document the unavailability of effective community-based infrastructures to serve in this capacity.
  iii. County and State PEI plans must include a description of relationships, such as partnerships, collaborations, or arrangements with community-based organizations, such as schools, primary care, etc. Plans must document how those relationships will ensure effective delivery of services and the county's ability to effectively coordinate, manage, and monitor the delivery of services.

iv. County PEI plans must strengthen and build upon the local community-based resources, mental health services, and primary care services.
v. County PEI plans will be evaluated based on their ability to reach underserved populations at the earliest point of contact.

7. **Integrated and Coordinated Systems:**

- Principle: In order to extend the impact of MHSA PEI funding and make PEI services accessible to the diverse people who need them, county and state PEI program design builds integrated and coordinated systems, including linkages with systems not traditionally defined as mental health, which reflect mutually beneficial goals and combined resources to further those goals.
- Criteria:

i. County and state PEI program designs demonstrate coordination with all components of the MHSA, including community services and supports, workforce education and training, innovation, and capital improvements/technology.
ii. County and state PEI program designs demonstrate coordination with local and state initiatives that support MHSA outcomes.
iii. County and state PEI programs demonstrate links with community agencies and individuals who have established, or show capacity to establish, relationships with at-risk populations, including those that have not traditionally been defined as mental health.
iv. PEI approaches emphasize comprehensive community-based and client/family-based approaches.

8. **Outcomes and Effectiveness**

- Principle: County and State PEI programs will participate in the development and use of a statewide evaluation framework that documents meaningful outcomes for individuals, families, and communities.
- Criteria: County and state PEI plans include well-conceived strategies to assess the effectiveness and outcomes of their programs, and reflect what is learned to all levels of the system in order to improve services and outcomes.

9. **Optimal Points of Investment**

- Principle: In order to maximize the effectiveness of MHSA PEI funding, county and state programs invest in optimal points of intervention. Optimal points of investments are defined as those interventions, targeted at a specific population and/or age group, which have the highest probability to divert negative outcomes, and/or generate cost savings.

10. **User-Friendly Plans:**
    - Principle: County and state PEI Plan will be accessible.
    - Criteria: County and state PEI program requirements and ensuing plans are written in accessible language that allows for reasonable implementation at all levels and supports the development of culturally and linguistically relevant services.

11. **Non-Traditional Mental Health Settings:**
    - Principle: County and State PEI programs shall increase the provision of culturally competent and linguistically appropriate prevention interventions in non-traditional mental health settings, i.e., school and early childhood settings, primary health care systems, and other community settings with demonstrated track records of effectively serving ethnically diverse and traditionally underserved populations.
    - Criteria:
        i. Counties will conduct a workforce and capacity assessment that will identify their own capacity for serving ethnically diverse and traditionally underserved populations as well as the capacity of community-based organizations with demonstrated track records in serving these populations. This assessment will be available to the public.
        ii. The capacity assessment will assess gaps in services to determine areas of greatest need.
        iii. Counties must document their efforts to identify, outreach to and collaborate with community-based organizations, primary care providers, mental health providers, parents and care givers, early childhood education providers, teachers, faith based organizations and traditional healers. Plans must document how those relationships will ensure effective delivery of services and the county's ability to effectively coordinate, manage, and monitor the delivery of services.
        iv. County PEI plans must strengthen and build upon the local community-based mental health and primary care system, including community clinics and health centers.
        v. Prior to establishing new programs by the county to its own county infrastructure, Counties must document the inability of community-based providers/infrastructure to serve in this capacity.
        vi. Counties shall include in their provider network community-based organizations that meet the identified needs of all consumers, with a specific emphasis on those who are traditionally underserved.
        vii. Local PEI plans will be evaluated based on the ability to reach underserved communities and address specific barriers to access faced by underserved communities, including cultural and linguistic barriers.

12. **Non Supplantation**

- Principle: PEI funds shall not supplant existing funding nor shall it be used to circumvent current funding requirements.
- Criteria: For each program funded with PEI funds there shall be a clear explanation of how funding to provide this service is not available from another resource.

Priority At Risk Populations

Below are priority populations as defined by the MHSOAC PEI Committee. Based upon the County Stakeholder process and prioritizing their communities' needs, Counties will identify their own target population from the list below. Counties will design programs specifically for the populations they identify from the list below. Populations are organized according to age. If statewide programs are approved, they will focus on the issues described below.

COUNTY POPULATIONS
A. Children & Youth, Ages 0-25, and their Families
Children and youth at risk of entering the juvenile justice system
Children and youth at risk of entering or in the foster care system
Children and youth at risk of school failure or underachievement
Infants and very young children with risk factors for developing mental illness (focus is on fostering positive relationships with parents/caregivers and supporting child care and early childhood education environments)
Children and youth "first break" (initial episode of a severe mental illness)
Children, youth, and their families that are homeless
Children and youth whose parents/caregivers have or are at risk for mental illness
Children and youth who are survivors of trauma
Children and youth from ethnic and racially diverse communities where research demonstrates they are at risk for specific mental health disorders (for example, Latinas at risk for depression & suicide)

B. ADULTS AND OLDER ADULTS
Adults and older adults at “first break” (initial episode of a severe mental illness)
Adults and older adults and their families that are homeless
Adults and older adults that are parents/caregivers and who have/are at risk for mental illness
Adults and older adults who are survivors of trauma
Adults and older adults at risk for unemployment
Adults and older adults who are at risk for or are already incarcerated
Adults and older adults at risk of school failure or underachievement
Adults and older adults from ethnic and racially diverse communities where research demonstrates they are at risk for specific mental health disorders
STATEWIDE TOPICS
A. ACROSS ALL AGES
Stigma Reduction
Discrimination Reduction
Suicide Reduction

Decision Point for the Commission: Prioritizing PEI Efforts by Age

Committee Consensus Finding: County and State PEI efforts shall focus prevention and early intervention strategies across all ages.

However, Committee members could not come to consensus with regard to the issue of PEI funding priorities with regard to age.

Several polarities, with important values at both ends, underlie the PEI Committee's challenges with coming to a consensus.

- Decision-making autonomy for counties reflecting input by local stakeholders vs. statewide priority direction set by the MHSOAC
- An implementation focus to maximize the impact of funding by concentrating initially on a few key populations vs. dispersing resources broadly to address the full spectrum of needs

Therefore Committee provides the Commission with the following four options:

Option One: Counties decide which age emphasis based on stakeholder input and identified need.

Option Two: Counties shall focus prevention and early intervention strategies across all ages.

Option Three: Counties shall focus prevention and early intervention strategies across all ages with an emphasis on individuals ages 0-25 and their families, with X% of funding dedicated to children, youth, adolescents, and transition age youth and their families.

Option Four: MHSOAC takes no action on prioritizing by age; not enough information available at this time.

Commission variation on Option Three[1]: Counties shall focus Prevention/Early Intervention strategies across all ages. However, given the fact that 50% of all lifetime cases of mental health disorders start by age 14, and 75% start by age 24, the Oversight and Accountability Commission will expect that county P/EI proposals place a significant emphasis on the 0 to 25 age population. Counties that do not place this emphasis will need to explain why.

[1] Please note that the Jerry Doyle amendment recommends no specific funding emphasis be attached to this priority.

References

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.